

Child's Name: _____ Date of Birth: _____

Diagnosis: _____

Allergies: _____

Medications: _____

Today's Date: _____ Form Completed By: _____

Please answer the following questions about your child's health and development so we can help with your needs.

Staff Only	Staying Healthy	YES	SOME -TIMES	NO
F/U	Medical Home: _____			
	1. Do you have a medical home (family doctor or clinic) that you go to when your child is sick or needs a check-up?			
	2. Does your child have regular check-ups with the medical home provider?			
	3. Are your child's immunizations up-to-date?			
	4. Are you happy with your child's weight?			
	5. Does your child sleep well at night?			
	6. Do you or your child brush his/her teeth at least daily?			
	7. Does your child have a check-up with a dentist every year?			
	8. Does your child have a soft formed bowel movement on a regular basis? (usually every other day)			
	9. Do you regularly fasten your child into a car seat?			

Name: _____ ID #: _____

	10. Do you understand the dangers of second-hand smoke on children?			
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Name: _____ ID #: _____

Staff Only	Managing Your Child's Healthcare	YES	SOME -TIMES	NO
F/U	Drugstore: _____			
	11. Do you understand your child's health problems?			
	12. Do you participate in your child's treatment? (medications, exercises, therapy)			
	13. Are you being taught how to do your child's treatments?			
	14. Are you continuing your child's treatments at home when the healthcare providers aren't present?			
	15. Do you feel that your child's identified needs are being met?			
	16. Do you know when, how much, and why your child gets medications? (prescription and over-the-counter, like Tylenol)			
	17. Do you know the side effects of your child's medications?			
	18. Are you able to get the medications, supplies, and/or equipment your child needs?			
	19. Are you able to pay for your child's dental care?			
	20. Do you know how to use your insurance and/or Medical Card?			

Name: _____ ID #: _____

Staff Only F/U	Becoming Independent	YES	SOME -TIMES	NO
	21. Is your child learning self-care activities? (feeding self, brushing teeth, bathing)			
	22. Is your child learning to do his/her share of family chores? (picking up toys)			
	23. Is your child responsible for his/her own toileting routine?			
	24. Does your child help himself/herself to get dressed?			
Staff Only F/U	Interacting with Others	YES	SOME -TIMES	NO
	25. Is your child able to communicate with others?			
	26. Have you begun to think about your child's future?			
	27. Do you and your child get to have some fun together every day? (playing games, telling stories)			
	28. Does your child spend time outside of your home during the week? (going with you on errands, meeting new people)			
	29. Does your child spend time with other children each week?			
	30. Do you have time to take care of some of your own needs?			

Name: _____ ID #: _____

Staff Only F/U	Commission Satisfaction	YES	SOME -TIMES	NO
	31. Are you pleased with the care you receive at the Commission?			
What would you like to see done differently:				

Information You Would Like to Have:

- | | | |
|--|---|---------------------------------------|
| <input type="radio"/> Growth & Development | <input type="radio"/> Medicaid | <input type="radio"/> Social Security |
| <input type="radio"/> Health Information | <input type="radio"/> Assistance Programs | <input type="radio"/> Transportation |
| <input type="radio"/> Education | <input type="radio"/> Counseling | <input type="radio"/> Other: _____ |

Your Comments:

STAFF USE ONLY: _____

Reviewed By:

Initials	Signature	Date